AFFIDAVIT OF ASSURANCE
OF BUSINESS COMPLIANCE

State of _____, County of _____

I, _____, being duly sworn upon by oath state:
Print your name here.

1) I am an owner/representative of _____ and hold the
Print your company name here.

position of _____ .
Print your job title here.

2) Our business was licensed by the Arkansas Board of Pharmacy as a:
Check one:

__ Wholesale Distributor of Legend Drugs
__ List I Chemical Supplier
__ Supplier of Medical Equipment, Legend Devices, Medical Gas
__ Hospital
__ Other: Describe_____

3) Our company's license permit, _____expired on December 31, 2006.
Print license number here.

4) I am aware that business permits issued by the Board are cancelled for non-payment on April 1, if proper fees are not paid.

Check one of the following:

__ Our company continued to operate without a permit after April 1

— Our facility continued to operate after April 1 but did not provide products or services in Arkansas which require a permit issued by the Arkansas State Board of Pharmacy after April 1.

Explain: _____

_____

— Other. Explain: _____

_____ (Owner's/Representative's Signature)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ _____
Notary Public (Print, Type, or Stamp Name Of Notary)

My Commission Expires: _____

Return to: Arkansas State Board of Pharmacy, 101 East Capitol, Suite 218, Little Rock, AR 72201
(Telephone: 501-682-0190)